

BARCODE SPACE HERE

HEALTH CLAIM TRANSMITTAL

Employer Name
Group (policy) Number



A. SUBSCRIBER/EMPLOYEE INFORMATION

| | | | |
|----------------------------|-------------|--------------------|---|
| Subscriber # or SSN: _____ | | Phone #: () _____ | |
| Last Name: | First Name: | MI: | Date of Birth: / / |
| Home Address: | | | New Address: Yes <input type="checkbox"/> No <input type="checkbox"/> |
| City: | | State: | Zip Code: |
| Spouse Last Name: | First Name: | MI: | Spouse Date of Birth: / / |

B. PATIENT INFORMATION

| | | | |
|--|-----------------------------|---|--|
| Last Name: | First Name: | MI: | Date of Birth: / / |
| Home Address: | | | |
| City: | | State: | Zip Code: |
| Sex: M <input type="checkbox"/> F <input type="checkbox"/> | Relationship to Subscriber: | Full Time Student: Yes <input type="checkbox"/> No <input type="checkbox"/> | School Name: School Phone #: () _____ |

C. ACCIDENT INFORMATION

| | | |
|---|---|-----------------------------|
| Work Accident: Yes <input type="checkbox"/> No <input type="checkbox"/> | Auto Accident: Yes <input type="checkbox"/> No <input type="checkbox"/> | Date Accident Occurred: / / |
| How did the accident occur? | | |

D. OTHER INSURANCE

| | |
|---|----------------------------------|
| Is the patient covered by another insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete the following: | |
| Name of person carrying other insurance: | Date of Birth: / / |
| SSN: _____ | Name of Other Insurance Carrier: |
| Policy Number: | Employer Name: |

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

Subscriber Signature: _____ Date: _____

E. ASSIGNMENT OF BENEFITS

Please sign below only if you want UnitedHealthcare to pay benefits directly to the provider of medical services.

Subscriber Signature: _____ Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Clip, do not staple, all bills to the completed form and mail them to UnitedHealthcare at the address listed on your ID card.
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to UnitedHealthcare in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include your Subscriber # or SSN on all documents.